Kansas HCBS FMAP Enhancement Projects

Presentation to House Social Services Budget Committee

January 19, 2022

Section 9817, American Rescue Plan Act: HCBS FMAP Enhancement

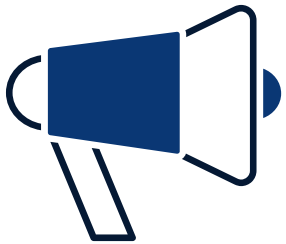
KDHE and KDADS submitted their joint FMAP Enhancement spending plan to CMS on July 9, 2021 and are awaiting full approval. CMS required states to make the following assurances:

- Kansas will use the federal funds attributable to the increased federal medical assistance percentage (FMAP) to supplement, and not supplant, existing state funds expended for Medicaid Home and Community Based Services (HCBS) in effect as of April 1, 2021;
- Kansas will use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- Kansas will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- Kansas will preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021;
- Kansas will maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

KDADS is expected to draw down approximately $80.3 million in additional federal match.

KDHE is expected to draw down approximately $4.9 million in additional federal match

KDADS gathered ideas from several key stakeholders across Kansas



Advocacy groups

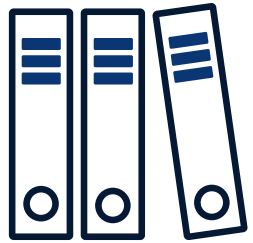
e.g., Interhab, Big Tent Coalition

Service providers

e.g., Aging and Disability Resource Centers, Managed Care Organizations

Government agencies

e.g., KDADS



Educational institutions

e.g., University of Kansas Lifespan Institute

In order to determine how to use the funding, KDADS leveraged several guiding principles

Maximize benefit to Kansas citizens

Ensure equity. Support full spectrum of eligible HCBS populations. Target underserved & minority populations.

Balance direct and indirect investments. Mix member services support with foundational enablers.

Invest in lasting impact and change

Balance near- and long-term benefits. Mix one-time benefits with systemic changes.

Measure, track & report impact. Compare future metrics to baseline to prove impact and streamline future budget enhancements.

Prioritize sustainable initiatives. Invest in continuity after funding is exhausted (e.g., initiatives with cost savings).

Ensure flexibility to meet evolving needs

Incorporate ability to scale pilot programs up or down. Align on decision milestone & leverage impact metrics.

Leverage flexibility of initial spending plan to re-evaluate needs during implementation process.

Fully utilize *all* Federal funding

Use all one-time funding. Slightly frontload expenditures and ensure exhaust funding by 2024.

Comply with requirements. Ensure compliance with Federal requirements where they exist.

The long list of ideas was narrowed down into three priority investment areas based on size of need and alignment to principles

Workforce

Improve DSW **retention and training** leading to enhanced capacity, quality of care, and career opportunities

Employment

Support disabled workers to **find integrated jobs** at employers who pay fair minimum wage

Access to care

Expand accessibility to HCBS through **transition management**, & increased **capacity**

The final investment portfolio has funding allocated across twelve initiatives

Investment area		Initiative	Investment
Workforce (~$57.1M)	1	One time retention bonus	**(~$51M)** Provides $2,000 bonus per worker
	2	Training grants	**(~5.1M)** Provides $200 training grant per worker
	3	Study and design career ladder	**(~$1M)** Investigates opportunity to create a career track
Employment (~$2.0M)	4	Study – Employment First Roadmap	**(~$2M)** Lump sum contractor rate
Access to Care (~$20.7M)	5	Short term internal staff	**(~$6.8M)** 16 HCBS FTEs (Final Settings & Admin); 5 Financial FTEs; 1 FTE Agency Project Manager
	6	Study – Waiting Lists	**(~$1M)** Lump sum contractor rate
	7	Transition Services	**(~$1.5M)** Extend existing grant processes
	8	Study – TCM Models	**(~$1M)** Lump sum contractor rate
	9	Mobile Crisis for I/DD	**(~$3.5M)** Provide I/DD response training to ~400 respondents
	10	SIM Consultant	**(~$30k)** Lump sum contractor rate
	11	Behavioral management training pilot	**(~$2M)** Train 10% of I/DD families (~1k)
	12	Remodeling grants – HCBS providers	**(~$5.4M)** Provide $50k to $100k grants for 50 to 100 providers
		Total	**~$80.3M**

Workforce

Workforce bonuses| Retention bonuses for Direct Service Workers improve retention rates leading to increased capacity for Kansans to receive care in their homes/community

Current state

- Kansas ranks 34th in Direct Service Workers (DSW) per HCBS waiver participant
- Kansas ranks 42nd in DSW wages
- DSW retention rate[1] is 15.8%
- On average, for every $1 per hour more a caregiver is paid, annual caregiver turnover decreases by 3%

Investment opportunity

- Provides bonuses to all DSW (~24k workers) to increase retention

Required financial investment

- Total initiative investment of $51M
  - $2,000 retention bonus per worker ($48.5M)
  - 5% administrative contractor fee ($2.5M)

Potential impact

- Increase DSW retention rates which…
  - Increases capacity for Kansans to receive care in their homes/communities
  - Reduces agency's recruiting and onboarding cost

- While this solves the short-term need, there is additional investment needed to create systematic change

Remaining gap

1. Number of caregivers who did not quit or get terminated in the year divided by the avg number of caregivers employed in the same period
Source: US Bureau of Labor Statistics; Kaiser Family Foundation

Workforce training grants| Workforce training ensures that direct service workers have the knowledge, skills, and abilities they need to provide quality support

Current state

- Minimum qualifications required to become a direct service worker
- Most DSW are trained through their provider/agency
  - 5 hours avg. onboarding training
  - 8 hours avg. ongoing training
- Large gaps in training available for specific needs (e.g., Autism)

Investment opportunity

- Training providers apply for funding to develop and train workers

Required financial investment

- Total initiative investment of $5.1M
  - $4.9M available for training
  - Grant amounts vary based on need; providers to apply for grants
  - 5% administrative contractor fee ($0.2M)

Potential impact

- Improves quality of care by ensuring DSWs have the knowledge, skills, and abilities to provide support
- Improves retention rate
- Provides DSW with skills needed to grow professionally and earn higher wages

- While this solves the short-term need, there is additional investment needed to fund on-going cost

Remaining gap

Source: Home Care Pulse

Workforce career ladder study| Designing a career ladder improves DSW retention rate while reducing workforce shortages in other health care occupations

Current state

- No defined DSW career ladder
- DSW retention rate is 15.8%
- Kansas' DSW wages of $23,530 lower than wages for other healthcare support occupations in Kansas ($28,700)

Investment opportunity

- Study and design a career ladder which allows Direct Service Workers to get promoted to other healthcare occupations with higher wages and a workforce need

Required financial investment

- $1M in one-time funding to hire contractors to study and design DSW career ladder

Potential impact

- Reduces turnover rate by incentivizing DSW to stay in job longer and get promoted
- Reduces workforce shortage in other health care occupations
- Increases direct service workers' career earning potential

Source: US Bureau of Labor Statistics; Home Care Pulse

Employment

Employment First | Studying how to make Employment First a reality enables Kansas to address employment gaps between those with and without disabilities

Current state

- Legally an Employment First state
- Employment disparity between those with and without disabilities
  - Labor force participation rate
    - Disability: 29%
    - No disability: 69%
  - Employment rate
    - Disability: 44%
    - No disability: 82%
  - Live above poverty line rate
    - Disability: 74%
    - No disability: 89%

Investment opportunity

- Hire a contractor to study how to make Employment First a reality (e.g., supported and integrated employment)

Required financial investment

- One-time investment of $2M

Potential impact

- Supports 9,100 individuals on the I/DD waiver find integrated and supported employment
- Long-term impact includes stimulating the economy, improving health and decreasing homelessness within I/DD community

- Additional ongoing funding needed to operationalize recommendations from study

Remaining gap

Source: US Census: CPS Annual Social and Economic Report; 2020 Annual Disability Statistics Compendium

Access to Care

Final Settings staff | Ongoing & intensive compliance oversight of Final Settings Rule necessitates additional KDADS staffing to prevent worsened HCBS capacity strains

Current state

- Historical underfunding leaves HCBS commission **understaffed**
  - Limits ability to deliver on HCBS expansions through FMAP
- ~15%[2] of HCBS providers are **at risk of failing Final Settings compliance**
  - Managing compliance oversight of approx. 2.5k providers necessitates additional FTEs

Investment opportunity

- Onboard **8 KDADS FTEs** to manage Final Settings compliance oversight

Required financial investment

- **~$2.5M** to cover FTEs for 3 years at $100k avg. annual salary[1]
- KDADS to seek **budget enhancement** to cover new FTEs once FMAP funding exhausts

Potential impact

- **Increase number of compliant providers** regarding Final Settings requirements to prevent worsened capacity crisis
  - Ensure **thorough & streamlined** compliance oversight processes
  - Expand internal bandwidth to **recruit HCBS providers**

1. Includes benefits, potential recruitment costs, and OEE

Waiting list study | Conducting a study on the HCBS waiver waiting list population assists KDADS in ultimately eliminating unmet treatment needs

Current state

- Lack of clarity in **level of need** amongst HCBS waitlist patients
  - **~6k individuals** on I/DD & Physical Disability waiting lists[1]
  - Portion of 6k likely **don't require full selection** of waiver services

Investment opportunity

- Contract a **detailed assessment** of the individual, varying needs of HCBS waiver waiting list patients to **optimize level of service provided** (i.e., resolve patient needs at lowest level of care required)

Required financial investment

- Minimal financial investment (**~$1M** lump-sum contractor cost)

Potential impact

- Enable KDADS to develop an **informed action plan** to **decrease waiver waiting lists**
  - E.g., seek alternative service approach for lower-need population
- Reserves limited HCBS waiver slots for **individuals with outsized needs**

1. KFF

Transition Services | Expanding transition services can further expedite departure from institutional care by supporting patients on an individualized basis

Current state

- LTSS[1] system relies too heavily on institutional services like NFs[2]
  - ~3k NF residents have **low care needs**[3]
- KS ranks 47th in effective transitions[3]
  - E.g., high frequency of **avoidable hospitalization**[3,4]

Investment opportunity

- Expand transition services
  - Assist patient transition out of facilities
  - Extend scope beyond individuals at risk of contracting COVID-19

Required financial investment

- **~$1 to $2M** in grants to cover services & assistive technologies not offered through MCO's transition policy
  - E.g., deposits, electronic devices

Potential impact

- Enable transition to HCBS for **individuals in institutional settings**
- Optimize **cost-effectiveness** by pivoting from institutional to HCBS
  - Adult day care is **2.5x less expensive** vs. NF care[5]

1. Long term services & supports 2. CMS 3. 2020 AARP Scorecard Report, 18.2% of total residents (~16k) 4. KS ranks 41st, ~16% of home health patients are hospitalized 5. Utilizes NFMH annual cost of care as proxy for NF cost ($47k – Kansas Disabilities Rights Center), ~$20k annual cost of adult day health care (Genworth)

TCM Study| Contracting a study of the TCM model will illuminate avenues to improve participant intake & referral processes while upholding strict quality assurance

Current state

- Long-term **shortcomings of TCM[1] model,** including:
  - Case manager conflict of interest (~**60%** of providers[2] employed by direct services agencies)
  - Tedious billing processes

Investment opportunity

- Contract a study to identify **avenues to improve current TCM** and explore **alternative models** (incl. health homes)

Required financial investment

- **~$1M** lump-sum rate to finance a contracted study

Potential impact

- Uphold **quality assurance** for ~1,800[3] participants using TCM annually
  - Eliminate conflicts of interest
- Leverage study to inform KDADS' potential next steps in actioning structural change, e.g.,
  - Explore revamped intake & **referral process detached from direct services**
- Streamline billing process to **minimize administrative burden** on case managers

1. Targeted case management 2. ~45 providers 3. Assumes 1:40 case manager/participant ratio

Mobile Crisis | Crisis respondent training fosters inclusion of I/DD participants in statewide mobile crisis efforts to prevent avoidable hospitalizations

Current state

- I/DD participant hospitalization poses **avoidable burdens to participants & the healthcare system** *(e.g., long stays, high readmissions, high cost of care)*
- Behavioral health mobile crisis teams are **not trained to address nuanced needs of individuals with I/DD**

Investment opportunity

- Build upon mobile crisis infrastructure investments underway *(e.g., $5M from KDADS behavioral health commission)*
- Ensure respondents are **equipped to manage I/DD participant crises**

Required financial investment

- **~$3.5M** investment covers statewide I/DD response training of mobile crisis teams 3 years[1] (before leveraging cost savings)

Potential impact

- **~$7M[2] in direct cost savings** by avoiding hospitalizations of individuals with I/DD (~1k individuals)[3,4]
- Ensure **effective** mobile crisis services are **accessible** to individuals with I/DD
  - Fill existing service gap in Kansas' care offering

1. Assumes $5k cost of training, 4 respondents per mobile crisis team, 30% annual turnover of respondents 2. Assumes ~$8k cost of care per I/DD hospitalization (Healthcare Cost & Utilization Project – HCUP) 3. Approx. 1k I/DD individuals referral to OSH & LSH annually (KDADS) 4. Assumes 15% utilization of mobile crisis amongst I/DD waiver population; 70% success of community resolution (SAMHSA)

SIM Consultant | Sequential Intercept Model (SIM) assessment will enable KDADS to mitigate disproportionate incarceration of individuals with I/DD

Current state

- Individuals with **I/DD are disproportionately enmeshed in the criminal justice system**
  - Account for ~10% of prison population vs. ~3% of general population[1]

> People with developmental disabilities can **engender [undue] suspicion** because they lack the necessary social cues…resulting in inappropriate responses[2]
>
> *Former sheriff & current employee at Lexipol*

Investment opportunity

- Hire one SIM expert to **identify gaps in Kansas' criminal justice system** & propose solutions to address said gaps

Required financial investment

- **~$30k** lump-sum contractor rate

Potential impact

- Leverage SIM mapping & assessment to illuminate actionable methods to,
  - **Prevent wrongful arrest & incarceration,**
  - **Shorten length of stay** in correctional facilities,
  - **Increase connectivity** to support services, and
  - **Reduce recidivism** rates for the I/DD community
- Reduce economic burden of providing support services in correctional facilities

1. Refers to US prison & general population, Petersilia: Doing Justice? Criminal Offenders with Developmental Disabilities 2. Lexipol (public safety policy & training solutions company)

Behavioral management training | Training family caregivers of children with disabilities prevents foster care & PRTF admissions in order to keep children in their home

Current state

- Medical & behavioral care of children with disabilities is **burdensome psychologically & financially**
- Parents of children with disabilities have **higher levels of psychological distress**

Investment opportunity

- Train **~850 family caregivers** (incl. biological parents, foster parents & other guardians) in behavioral management practices
  - 15% of target population[2]

Required financial investment

- **~$2M** to cover approx. $2.5k training per family *(includes trainer fees, supplies, etc.)*

Potential impact

- **~15% of target population[2]** (850 families) trained in behavioral management training
- Approx. **120 children** kept out of foster care & PRTFs[3]
  - **~$5M in costs avoided** by keeping children in their homes[3]

- ~85% of target population (~4,800 families) still unequipped

Remaining gap

1. Assumes 20% of children in pilot are at risk of entering foster care or PRTFs, 70% success of rate of behavioral management training
2. Children enrolled on HCBS waivers in KS 3. Assumes ~$65k annual cost of PRTF care & ~$20k annual cost of foster care per child, Saint Francis PRTF, KVC PRTF, Foster care news letter

Remodeling grants | Provider grants cover the financial burden of remodeling required to fulfill HCBS setting standards

Current state

- Participant **choice of care setting is restricted** by lack of HCBS capacity (KS ranks 44th in adult day service capacity[1])
- ~15%[2] of HCBS providers are **at risk of failing Final Settings compliance**

Investment opportunity

- Provide **direct grants to providers** to cover costs to reach compliance
  - E.g., renovation to provide community care setting

Required financial investment

- **~$5M** in one-time grants to 50 to 100 providers in underserved communities (e.g., based on SVI[3] score)
  - ~25k to 50k to cover application review administrative process

Potential impact

- Prevent worsened capacity strains
  - Ensure **continuity of care** at 50 to 100 target facilities
  - Mitigate **inequitable access** to care
- Improve **quality** of care & maximize **choice of setting** for up to ~5,000 individuals[4]

- ~75% of target population (~300 of 400 total providers) may require additional support in fulfilling Final Settings requirements

Remaining gap

1. 2020 AARP LTSS Scorecard Report 2. ~400 of ~2,500 total settings 3. Social Vulnerability Index (SVI) 4. Assumes ~50 distinct individuals served at each facility

KDHE-Sponsored Projects

KDHE-Sponsored Projects| Community Based Resources, Housing & Homelessness, State Infrastructure, HCBS Provider Training, STEPS Pilot Evaluation

KDHE has proposed five (5) distinct projects in the Kansas HCBS FMAP Project Plan:

- Community Health Worker Funding ($2.0 million)
- MCO Housing Investment Incentives ($1.0 million)
- MMIS Work for Pondera Solution ($100,000)
- HCBS Provider Training ($600,000)
- STEPS Pilot Evaluation ($150,000)

The KDHE-sponsored FMAP projects total $3,850,000.

Questions?